

# A Health Status Report on African Americans in Connecticut

June, 2007



The Connecticut State Conference of  
NAACP Branches Health Committee

# **A HEALTH STATUS REPORT ON AFRICAN AMERICANS IN CONNECTICUT**

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**“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”**

**Dr. Martin Luther King, Jr.**

**“Improving the health of communities of color is one of the greatest challenges facing America. Despite improvements in health and healthcare across the board, African Americans continue to suffer significantly worse health outcomes than their white counterparts in many disease areas.”**

**Julian Bond, Chairman  
National Board of Directors, NAACP**

## **Diseases and Conditions**

**“Health disparities are differences in the incidence, prevalence, mortality and burden of diseases and other health conditions that exist among specific population groups in the United States.”**

**“National Institutes of Health”**

## **Delivery of Services**

**“Health care disparities are racial/ethnic differences in outcomes or quality of care that are indicative of injustice within the health care system or in the behavior of health care providers.”**

**Thomas A. Laveist  
Professor of Health Policy and Management  
&  
Director of the Center for Health Disparities Solutions  
Johns Hopkins Bloomberg School of Public Health**



### Message from the State President

One of the most important issues of today is social injustice as it pertains to access and quality of care for all Americans and particularly for African Americans. This report, developed by the Connecticut State Conference of NAACP Branches – Health Committee, has reviewed historical, prospective, and qualitative data to highlight the ongoing challenges of African Americans in Connecticut as they relate to continued inequities in health care.

The report is alarming, in that African Americans in Connecticut, despite the significant economic wealth of the state, continue to suffer and bear the burden of excessive disease, death, disability, and dissatisfaction. The report tells members of the Connecticut State Conference of NAACP Branches that there is much to do relative to continued social injustice in health care. This report highlights not only the significant gap in morbidity and mortality between the majority population and the African American community, but also the direct cost, to this state, of maintaining two separate systems of care—one for the majority population and another for people of color.

The recommendations of this report, which outline the need for system changes, are fully supported by the Connecticut State Conference of NAACP Branches. The state conference itself will work with our state's leadership to achieve these necessary changes.

We are indeed thankful to the Connecticut Health Foundation for giving the Connecticut State Conference of NAACP Branches a voice in the continuing dialogue about access and quality for all residents. The recommendations will benefit each and every citizen of this state while highlighting injustices that must be addressed with willing partners.

Scot X. Esdaile  
President  
Connecticut State Conference of Branches  
Board Member National NAACP





### Message from the State Health Committee Chairman

The CT State Conference of the NAACP, with the support of the CT Health Foundation, is pleased that we have been able to analyze at the macro (state) level the health status of African Americans in Connecticut. We would also like to thank the New Alliance Foundation for their support of this project. Our study methodology was designed in such a manner that other state conferences can employ this same process to analyze their population.

The results of our analysis present many opportunities for improving the health status of African Americans where significant gaps have been identified. Overall the report points to some alarming statistics. The data, both quantitative and qualitative, have been arranged in a manner that facilitates systemic improvements. However, equally important, the data contained within this report can be applied as a tool at the neighborhood and local branch level.

Particularly noteworthy, at the state level, are the significant dollars, at risk, that are a direct cost to the State of Connecticut and its citizens. Issues related to access dominate the findings as well as the best use of healthcare dollars. This report does not attempt to quantify the indirect cost to the state in terms of the sequalae of excessive morbidity and mortality. Also not measured in this

report are the costs of disabilities and loss of productive days that are a significant burden on our state's economy. Allowing these inequities to continue is unacceptable.

We believe our recommendations, based on data, are consistent with the desired health status of all Connecticut residents, regardless of their race and ethnicity. We believe that this report should serve as a call to action. Our desire, at the NAACP State Conference, is to dismantle the framework that underpins the disparities cited in this report. We hope to close the gaps, illustrated by health issues, that we have used as surrogates and also to address the tremendous cost of excessive morbidity and mortality to individuals, families, and the state.

James Rawlings  
Chair, Health Committee  
Connecticut State Conference of NAACP Branches

## I. EXECUTIVE SUMMARY

The purpose of this Health Status Report is to estimate the prevalence of various health conditions and the impact on African Americans principally living in Connecticut. In addition, it estimates the occurrence of other health markers such as insurance status and hospital utilization. The report calculates relative measures of these health conditions and markers in racial and ethnic minorities compared with the general population.

Healthcare disparities among Connecticut's African Americans are long-standing conditions that have been inadequately addressed in the past. To date, the exact causes of racial and ethnic health disparities, both nationally and on a state level, have not been determined. This Health Status Report, which covers health conditions principally of Connecticut residents, aged 18 and over for the period 2000–2004 and beyond, reveals that compared with Whites, Blacks and Hispanics were more likely to be in fair or poor health. African Americans in Connecticut continue to lead the state in the prevalence of most chronic health illnesses reported. It is clear that health disparities in Connecticut exist and are indeed very prominent in the lives of African Americans.

This Health Status Report should not be viewed as a strategic plan, but rather as a tool that indicates the need for the State of Connecticut to develop a comprehensive, time-phased, strategic plan to address healthcare disparities within Connecticut's African American population. A plan, with clear goals, objectives, and timetables, is necessary to address this complex problem. Any efforts to eliminate racial and ethnic disparities in Connecticut must be comprehensive in scope and include measures to address **seven major root causes** identified in

the Health Status Report: 1) Perception of equality of healthcare services among Connecticut's white population, 2) Lack of a voice among Connecticut's African American population concerning healthcare disparities, 3) Socio-economic factors (poverty), 4) Socio-cultural factors (hearsay, rumors, folk tales), 5) Environmental factors, 6) Lack of health insurance, and 7) Lifestyle behaviors.

The report highlights that we can not continue as two communities, one white and healthy and the other black and ill. Without question the income disparity between rich and poor in Connecticut, which continues to widen, is a major contributor to health disparities for Connecticut's African American population. A major determinant of health and longevity is one's socio-economic status. The lower one is on the socio-economic ladder the greater the possibility of poor health and death at an early age. The rate of children in poverty among Connecticut African Americans was 1.7 times the national average. In 2000, the Urban Core accounted for only 18.8% of the state's population but 48% of the state's population living in poverty. The state has too much concentrated poverty to be viewed in average terms.

***Further in general, clinicians view symptoms, diagnoses, and treatments in ways that sometimes differ from the clients' views, especially when the cultural backgrounds of the consumer and provider are dissimilar.*** This difference of viewpoints can create barriers to effective care. Clinicians and service systems, naturally immersed in their own culture, have been ill-equipped to meet the needs of patients from different backgrounds and, in some cases, have displayed bias in the delivery of care.

**Preventable hospitalizations** are instances of inpatient hospital care for Ambulatory Care Sensitive Conditions (ACSCs). They are considered “preventable” because timely and effective primary care and medical management have been clinically demonstrated to significantly reduce the need for hospitalization for these widespread health conditions. ACSC total charges in Connecticut increased from \$611 million to \$893 million (46.2%) during FYs 2000–2004. Minorities accounted for more than half of the recent increase in ACSC hospitalizations. Compared with all races combined, Blacks had higher rates for 11 of the 16 ACSCs, meaning they were more likely to be hospitalized for these conditions. Blacks had rates twice as high as or greater than all races combined for adult and pediatric asthma, all diabetes conditions, hypertension, and lower extremity amputations. **Based upon this data, it is estimated that 2008 ACSC charges in the State of Connecticut alone will exceed \$1.1 billion.**

Additionally, as an example of the full impact of one of these conditions individuals who suffer from diabetes are likely to have kidney complications known as End Stage Renal Disease (ESRD) plus many other complications. The two leading causes of ESRD are uncontrolled hypertension and uncontrolled diabetes. African Americans are over represented in the ESRD population and therefore are at higher risk for this condition. African Americans who are only 9.1% of the State's population are 30.2% of the dialysis population in Connecticut. **The annual ESRD cost per patient approximates \$90,000.**

In general, most people were able to get the care they needed, but 7.1% of Whites, 15.5% of Blacks, 18% of people of other races, and a full 22.4% of Hispanics were unable to get needed care because of cost.

How health care is delivered and by whom are important factors, given the historical cultural experience of Connecticut's African American population. The legacy of the infamous Tuskegee experiment in the 1930s has lingered in the consciousness of African Americans and, consequently, a fear factor is etched into the subconsciousness of Connecticut's African Americans relative to health matters. Fear produces barriers that can prevent one from making intelligent decisions. This is significant when we see that African Americans are underrepresented in clinical research trials for new drugs. This suggests that some health disparities are internally driven in the Black community. The high death rate from prostate cancer among African American men can be traced, largely, to a lack of early detection and a reluctance to undergo the necessary preventive measures because of fear or religious beliefs.

This report calls for a number of significant changes in the current system, such as:

- Merging the departments of public health and social services at the state level in order to integrate goals, improve program and system outcomes, and reduce healthcare costs.
- Creating an Office of Minority Health to address minority health issues and healthcare inequities to review legislative policies and bills relative to unintended negative outcomes and to coordinate the various state and initiatives to reduce and eliminate health disparities and inequalities in the State of Connecticut.
- Encouraging the Connecticut Business and Industry Association to support and invest in health prevention and promotion efforts in order to reduce costs and increase economic stability of this state.

- Establishing academic medical center, Schools of Public Health, and Nurse School and other allied health schools accountability in order to promote the hiring of minority clinical staff and training of future care providers and leaders.
- Marrying healthcare licensing and approvals with diversity initiatives in order to promote Health Care outcome equality.
- The Connecticut State Conference of NAACP Branches, with more than 10,000 members statewide, will become the “**Healthcare Voice**” and assume the lead in advocating with Connecticut’s General Assembly to enact comprehensive health care legislation. This advocacy will be in the form of statewide **Participatory Action Work Groups (PAWG)** involved in a proactive campaign to include an aggressive effort to educate the state’s African American community about existing healthcare disparities and the role each individual and community can play in improving Health Care outcomes for all.

## II. INTRODUCTION

The National Association for the Advancement of Colored People (NAACP) was founded on February 12, 1909 (the Centennial of the birth of Abraham Lincoln) to fight for civil and political liberty. The NAACP has addressed social injustice for nearly 100 years. The NAACP Health Care Committee, established in the 1930s, has maintained its interest in and commitment to eliminating barriers that promote and foster health disparities and the significant health crisis that impacts African Americans and other people of color.

Health care has been a priority in the Connecticut NAACP branches for nearly 25 years. The New Haven branch has the largest annual one-day community health and career fair, specifically geared to African Americans and other socio-economically challenged groups in the New England region. It is estimated that this health fair attracts approximately 1,500 African Americans in the New Haven region, annually. The fair is information driven and places attendees in direct contact with numerous regional healthcare service providers. The fair is intended to empower the African American community with healthcare information that will assist individuals and families in making informed decisions and choices. *The Connecticut NAACP realized that, unfortunately, the fair could do little to address the major health disparities prevalent among Connecticut's African American population. It became obvious that something more was needed.*

In September 2004, the Connecticut State Conference of NAACP Branches, under the direction of a Blue Ribbon Health Advisory Committee, developed a preliminary Health Status Report on African Americans residing in Connecticut. The report focused on HIV/AIDS and was intended



to examine how one disease was undermining the life expectancy of African Americans. It was to be used as a template for a future comprehensive assessment and understanding of the root causes of healthcare disparities that plague the African American community.

In 2005, the Connecticut Conference of NAACP Branches Health Committee began to explore healthcare disparities among African Americans living in Connecticut. Through a grant provided by the Connecticut Health Foundation, the Blue Ribbon Committee analyzed statistical data and interviewed individuals from Connecticut's Urban Core to determine the extent and impact of healthcare disparities on the lives of African Americans in Connecticut. This Health Status Report captures significant aspects of the multidimensional healthcare disparities, identified through an intensive assessment of available data and focus groups, comprising Africans Americans from Connecticut's urban areas. However, this report goes beyond the standard methodology of analyzing healthcare disparities organized around specific conditions or diseases, and considers other factors such as health behaviors, culture, and socio-economic status and attempts to shed light on the full impact of disparities on the quality of life of many communities and the economic impact on our State.

Health care is an extremely complex issue. For example, formal research on this subject indicates that socio-economic status is a factor that has an impact on health outcomes. The precise relationship between socio-economic and health status has not been determined. Most people assume access to health care explains everything. However, you still find a close relationship between socio-economic status and health disparities in countries with universal health care. This

is the case in England despite England's National Health Service.<sup>1</sup> In a small state like Connecticut, where the very rich and the very poor live in close proximity, the unequal distribution of wealth has to be factored into any long-term solution to eliminate healthcare disparities among Connecticut's African American population.

The Health Status Report is limited in identifying the many factors that impact healthcare disparities among Connecticut's African American population. What should be clear from this report is that analyzing statistical data does not reveal all the underlying factors that cause racial and ethnic disparities in Connecticut and the full impact on many communities of color. Existing research easily quantifies healthcare disparities, but is greatly lacking in explaining why they exist. It is extremely important to understand why disparities exist for effective solutions and outcomes to be achieved. This Health Status Report does attempt to identify some but not all possible root causes of healthcare disparities among Connecticut's African American population. **Additionally, the Health Status Report provides a framework that will elevate the public discourse to a level where a comprehensive approach is developed and implemented to eliminate racial and ethnic disparities in Connecticut.**

**Health disparities are the civil rights issue of the 21st century!**

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<sup>1</sup> Center for the Advancement of Health, Facts of Life: Issue Briefings for Health Reporters Vol 3, No. I, January 1998. <http://www.cfah.org>

**“For the United States to realize the full potential of its democratic goals and creed, we need the talents of every one of our citizens. The health status of African Americans and other minority groups is important to the nation as a whole.”**

**Louis Sullivan, Former Secretary  
U.S. Department of Health & Human Services  
1989-93**

### III. METHODOLOGY

The study methodology consisted of six distinct components:

**First**, the Blue Ribbon Health Advisory Committee, a panel of experts from various health backgrounds, was selected to guide the process. The NAACP Connecticut Statewide Blue Ribbon Health Advisory Committee promotes a strategy that examines, comprehensively, the shortcomings of both qualitative and quantitative data, approaches, and action steps for broadening success. The vision of the Blue Ribbon Committee is the elimination of health disparities in the State of Connecticut.

**Second**, the Blue Ribbon Health Advisory Committee hired an investigative consultant to review and examine publicly available quantitative data from state and national surveillance systems as well as from medical literature. The purposes of the analysis were to:

- Estimate the prevalence of various health conditions, such as diabetes, heart disease, asthma, HIV/AIDS, lead poisoning, sickle cell disease, etc. in members of various racial and ethnic groups living in Connecticut.
- Estimate the prevalence of other markers of health such as insurance status, hospital utilization, immunization rates, and others in members of various racial and ethnic groups living in Connecticut.
- Calculate the measures listed above for particular subgroups of the population (e.g., by age group, sex, and income level) and compare rates across these strata.
- Calculate relative measures of health conditions and health markers in racial and ethnic minorities compared with whites.

**Third**, in order to have a qualitative perspective, the Blue Ribbon Advisory Committee hired a health researcher to interview focus groups members for qualitative analysis. The purpose of

conducting a qualitative analysis for the Health Status Report was to provide an in-depth and reflective look at the lived experience of health disparities among African Americans in Connecticut. The qualitative method of choice was focus group discussions, which enabled participants to express their experiences through dialogues with each other and with the moderator. Each group provided a forum for critical thinking and reflection on the issues experienced by health disparities.

**Fourth**, the leadership of the Connecticut NAACP reviewed hospitalization statistics from acute care facilities from across the State and examined information to address utilization and morbidity perspectives. The Connecticut Office of Health Care Access provides preventable hospitalization data to municipal health officials, regional agencies, coordinating health services, and hospitals for use in health planning and designing community outreach programs. Current statistics for 31 hospitals operating in Connecticut were reviewed and analyzed.

**Lastly**, a review of past and present state legislation was undertaken by a consultant to analyze the intended or unintended consequences of legislation and policies, relative to their impact on exacerbating health disparities in this state.

The preceding methodology was designed with the precise intent that other state conferences of the NAACP could replicate this model to analyze, efficiently and effectively, the health status of African Americans within their specific state conferences.

## IV. BACKGROUND

The 2000 census information indicates that Connecticut's overall population is 3,405,565, of which 2,780,355 (81.6%) are classified as White, 309,843 (9.1%) as Black or African American, 320,323 (9.4%) as Hispanic or Latino, and 82,313 (2.4%) as Asians.<sup>2</sup>

Connecticut's black population is heterogeneous in composition. Persons of Sub-Saharan and east African ancestry are referred to as "African American," or "blacks." Today, although the vast majority of African Americans in Connecticut are U.S. born, many blacks are immigrants from African nations and non-Hispanic Caribbean countries, most notably Jamaica, Haiti, and Trinidad and Tobago. More than half of non-Hispanic Caribbean immigrants have entered Connecticut since 1980, forming communities in Hartford, New Haven, and Bridgeport.<sup>3</sup>

Contrary to popular perceptions, Connecticut is **not** balanced in terms of socio-economic indicators. In particular, individual towns can be categorized into five distinct, enduring, and separate groups. The groups are:

- **Wealthy** Connecticut has exceptionally high income, low poverty, and moderate population density.
- **Suburban** Connecticut has above average income, low poverty, and moderate population density.
- **Rural** Connecticut has average income, below average poverty, and the lowest population density.
- The **Urban Periphery** of Connecticut has below average income, average poverty, and high population density.
- The **Urban Core** of Connecticut has the lowest income, highest poverty, and highest population density [Hartford, Waterbury, New Haven, Bridgeport, and New London].<sup>4</sup>

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<sup>2</sup> U.S. Census, 2000, Connecticut

<sup>3</sup> Connecticut Department of Health: Multicultural Health Report, June 1999

<sup>4</sup> University of Connecticut, Center for Population Research. The Changing Demographics of Connecticut—1990 to 2000. Part 2: The Five Connecticut. Storrs, Connecticut. May 2004. Available at <http://popcenter.uconn.edu>

Connecticut is the most affluent state in the nation. However, its Urban Core areas have some of the nation's poorest populations. It would be easy to conclude that healthcare disparities are most common among African American residents living in Connecticut's Urban Core. The Health Status Report found that health disparities exist among African Americans of all income levels wherever they reside in the state. Generally, having health insurance does not guarantee equal access to health care. Moreover, getting in the door of a doctor's office does not equal receiving services that one needs, and may have nothing to do with the intensity or the quality of the services provided.<sup>5</sup>

Racism is often cited as one factor that contributes to the African American perception of receiving inadequate healthcare. However, the Henry J. Kaiser Family Foundation conducted a survey of 5,500 people to determine public perceptions of race and health care. Compared with other sectors (workplace, education, housing), racism in medical care was viewed by black and Hispanic persons as less of a major problem.<sup>6</sup> The survey also found that different populations view their ability to receive care very differently. **When asked how they perceive quality of care for blacks and whites, about 70% of black persons perceive that they receive lower quality care than white persons. About 67% of whites surveyed believe that blacks receive**

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<sup>5</sup> United States Department of Health and Human Services. Agency for Healthcare Research and Quality. Strategies to Reduce Health Disparities: Access to Services. Presenters: Robert M. Ayberry, M.P.H., Ph.D., Director, Morehouse Medical Treatment Effectiveness Center, Morehouse School of Medicine, Atlanta, GA & Robin M. Weinick, Ph.D., Director, Intramural Research, Center for Primary Care Research, Agency for Healthcare Research and Quality (AHRQ), Rockville, MD. Available at <http://www.ahrq.gov/news/ulp/dispar/dispar4.htm>

<sup>6</sup> United States Department of Health and Human Services. Agency for Healthcare Research and Quality. Strategies to Reduce Health Disparities: Cultural Competence. Presenters: Marsha Lillie-Blanton, Dr.P.H., Vice President, Health Policy, The Henry J. Kaiser Family Foundation, Washington, DC & Tawara D. Goode, M.A., Director, National Center for Cultural Competence, Child Development Center, Georgetown University Medical Center, Washington, DC. Available at <http://www.ahrq.gov/news/ulp/dispart7.htm>

the same care as whites do. Similar differences are identified between Hispanic and white persons.<sup>7</sup>

*The perception by Connecticut's white population concerning the equality of healthcare services is important, because they are the dominant population group (81.6%), and Connecticut's healthcare system is controlled, managed, and delivered primarily by members of the white population.* If the perception exists among Connecticut's white population that African Americans receive equal healthcare services, then racial and ethnic healthcare disparities may not be viewed by policy makers and medical professionals as a significant issue. *This perception can result in a lack of urgency about healthcare disparities.* Equally important is the lack of a voice by Connecticut's African American communities concerning inequalities in the healthcare system that would expel this erroneous perception, which in fact perpetuates racial and ethnic healthcare disparities. *Such a perception, if it exists among Connecticut's white population, combined with the lack of a voice among the African American population, could be a root cause of healthcare disparities among Connecticut's African American population.* The lack of a voice is for the most part the product of a lack of understanding. These are areas that need to be explored further to understand why essential differences in perception regarding racial and ethnic healthcare exist.

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<sup>7</sup> Ibid.



**“Communities of color suffer disproportionately from diabetes,  
heart disease, HIV/AIDS, cancer, stroke and infant mortality.**

**Eliminating these and other health disparities is a priority of HHS.”**

**Tommy Thompson  
Former Secretary  
U.S. Department of Health & Human Services**

## **V. OVERVIEW OF HEALTH STATUS OF AFRICAN AMERICANS IN CONNECTICUT**

The Connecticut State Conference of NAACP Branches Health Disparities Report presents an overview of the health status of African Americans as compared to that of the White population in Connecticut. The Health Status Report reviewed data from Connecticut's major health disparity indicators as identified in a variety of publicly available data sources as well as information from state and national surveillance systems and from the medical literature. These data sources are as follow:

Behavioral Risk Factors Surveillance System

National Survey of Children's Health

Surveillance, Epidemiology and End Results Database

Connecticut Department of Public Health vital statistics

Connecticut Hospital Discharge Abstract and Billing database

Connecticut Family Health Care Access Survey

The report includes interpretations of the statistics, a description of the datasets used and the targeted populations, and limitations of the data and associated analyses. For this report, we reviewed Birth Weight, Prenatal Care, Cancer, and Children to present an overview of health conditions and health markers in racial and ethnic minorities compared with whites.

- **Birth Weight**

The total number of births in 2000 was 43,075, 42,659 in 2001, and 42,826 in 2003. As shown in Table 1, compared with Whites, Black and Hispanic mothers were more likely to bear low birth-weight babies. Compared to white babies, black babies were 1.40 times as

likely to be born prematurely. Compared to white babies, black babies were 1.97 times more likely to have low birth weight. Mothers of other races were only slightly more likely than Whites to have babies with low birth weight. Similarly, Black and Hispanic mothers were more likely than Whites to bear premature babies.

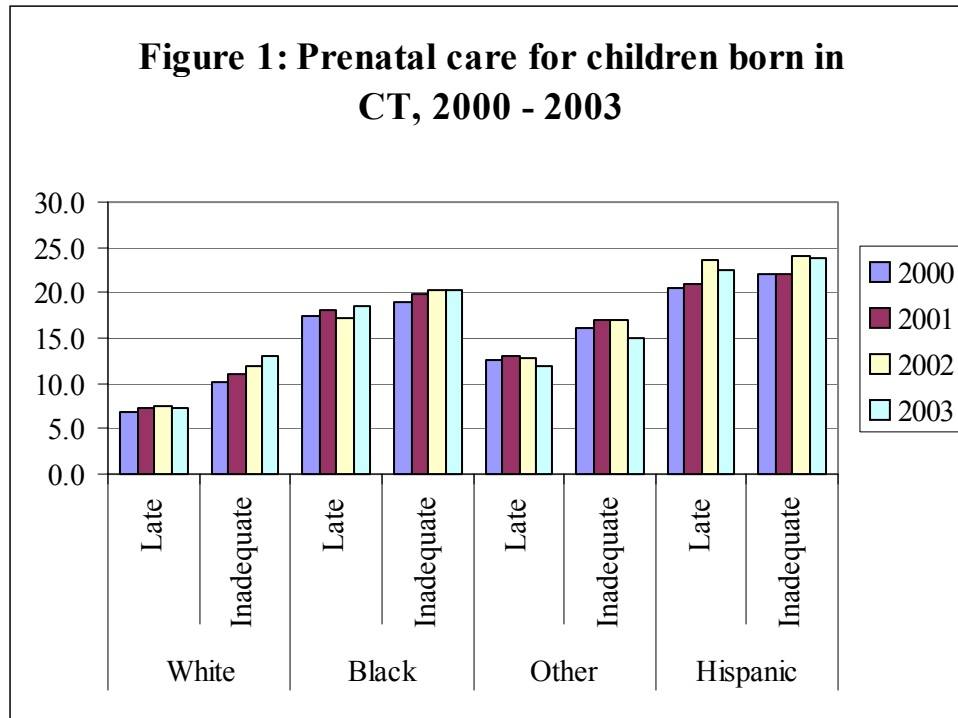
<b>Table 1: Characteristics of children born in CT, 2000–2003 (%)</b>				
	<b>White</b>	<b>Black</b>	<b>Other</b>	<b>Hispanic</b>
<b>2000</b>				
low birth weight	6.4	12.1	7.1	8.7
premature	9.3	13.6	9.1	12.2
<b>2001</b>				
low birth weight	6.3	12.4	8.2	8.1
premature	8.9	13.2	10.2	10.5
<b>2002</b>				
low birth weight	6.7	12.8	9.2	8.0
premature	9.5	12.3	8.8	10.4
<b>2003</b>				
low birth weight	6.4	12.6	7.6	8.7
premature	8.8	12.3	7.9	9.9

**Source: Center for Disease Control - National Survey of Children’s Health (NSCH) 2004.**

- **Prenatal Care**

As illustrated in Figure 1, compared with white mothers, black and Hispanic mothers were more likely to receive prenatal care late in pregnancy. The odds ratio for inadequate prenatal care for babies born during 2003 for Blacks, Hispanics, and other races compared with Whites were 1.61, 1.85, and 1.20, respectively. Mothers who are black or Hispanic, as well as mothers of other minority races, were also more likely to receive care classified as inadequate. Compared to white mothers, black mothers are more likely to give birth as teenagers, although there has been a decline in the teenage birth rate for both groups since

2000. For the years included in this study, children of black mothers were significantly more likely to experience premature deaths than children of white mothers.



Source: Connecticut Department of Public Health – Vital Statistics 2004

- **Cancer**

Table 2 indicates that one health condition of particular and continuing interest in Connecticut is cancer. Cancer ranks higher than heart disease, in terms of age-adjusted death rates, among persons under age 65 in Connecticut. Cancer is the second leading cause of death in Connecticut and in the United States. It is also the leading cause of premature mortality in Connecticut. The decline in death rates from heart disease for persons under 65 has been greater than for cancers. The Health Status Report has reported on cancer of the

prostate, breast, lung, and cervix, because they greatly affect African Americans in Connecticut.

Site of Cancer	White Male	White Female	Black Male	Black Female
All sites	593.3	456.0	636.1	382.4
Digestive System	119.5	78.3	135.9	94.2
Colon and Rectum	70.6	51.1	61.5	58.9
Liver	6.1	2.0	11.2	2.2
Pancreas	13.5	10.0	16.9	12.4
Respiratory system	94.2	60.2	115.8	52.9
Lung and bronchus	85.6	57.7	100.8	50.5
Skin	30.7	20.5	1.8	1.6
Breast	1.7	145.5	3.1	116.7
Cervix	--	7.0	--	11.0
Uterus	--	29.3	--	18.3
Prostate	171.2	--	248.6	--
Brain and Nervous system	9.2	6.1	4.3	3.8
Lymphoma	28.8	20.6	19.9	14.8
Leukemia	15.9	9.6	11.5	7.2

**Source: Surveillance, Epidemiology and End Results (SEER) database (Cancer registry) 2003**

### **Prostate Cancer**

In 1997, 2,453 Connecticut men were diagnosed with prostate cancer. A total of 401 men died of prostate cancer in 1997. *The average age-adjusted death rates for prostate cancer per 100,000, during the period 1997–2001, was 66.3 for Blacks, 27.3 for Whites, and 23.7 for Hispanics.*<sup>8</sup> Prostate cancer is more common in African American men for reasons that are not fully known. African American men have a higher risk of developing and dying from prostate cancer compared with white males and Hispanic males. As men get older their risk of prostate cancer increases. Men who are at a higher risk of developing prostate cancer

<sup>8</sup> Center for Disease Control and Prevention Division of Cancer Prevention and Control. State Cancer Data for Connecticut. Available at <http://www.cdc.gov/CancerBurden/CT.htm>

should consider being tested at a young age. Men over fifty years of age are also advised to undergo a digital rectal exam of the prostate gland and also a prostate-specific blood test every year. Doctors all over the country are conducting clinical trials to better understand and treat prostate cancer.

### **Breast Cancer**

The most common cancer among women is breast cancer. The chance of a woman having breast cancer during her lifetime is 1 in 8. In Connecticut, nearly one-third of Connecticut breast cancers are still being detected at various regional and distant stages after some metastasis has occurred. Screening for breast cancer by mammography and clinical examination is recognized as being important in reducing the breast cancer mortality rate. Such procedures provide detection at an earlier stage. Breast cancer is one of only a few cancers associated with higher social class.<sup>9</sup> Higher incidence rates for breast cancer have been noted for Fairfield County (which includes affluent areas) and several towns statewide that have relatively high proportions of persons with higher incomes.<sup>10</sup> Although African American women were more likely than white women to have had a mammogram in the last three years, white women are slightly more likely to develop breast cancer than African American women. African American women are more likely to die of this cancer. *The average annual age-adjusted breast cancer mortality rates for women, during the period 1996–2000, was 33.1 for Blacks, 27.5 for Whites, and 12.4 for Hispanics.*<sup>11</sup> Many experts conclude that the main reason for this is that African American women have more aggressive tumors and enter into care later.

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<sup>9</sup> Connecticut Department of Public Health, Policy, Planning and Analysis. Looking Toward 2000-State Health Assessment. Available at <http://www.dph.state.ct.us>

<sup>10</sup> Ibid.

<sup>11</sup> Center for Disease Control and Prevention Division of Cancer Prevention Control, Atlanta GA. State Cancer Burden Data for Connecticut. Available at <http://www.cdc.gov/cancer/CancerBurden/ct.htm>

## **Cervical Cancer**

Towns or regions with relatively large proportions of women of lower socio-economic status, including Black, Hispanic and Asian groups have a higher incidence of cervical cancer.

Cervical cancer rates rise until the age of 45–49 years, with no clear pattern at older ages.

African American women had a higher cervical cancer death rate than white women. ***During the period 1990–1994, the crude incidence rates for invasive cervical cancer per 100,000 women were 12.8 (97 cases) for Blacks, and 8.8 (667 cases) for Whites.***<sup>12</sup> Many experts conclude that African American women are more likely to be diagnosed with a later stage of cervical cancer than white women.

## **Lung Cancer**

During the period 1989–1998 lung and other respiratory cancers accounted for 27% of the cancer deaths in Connecticut. Medical studies show a consistent relationship between decreased fruit and vegetable intake and increased cancer risk, especially cancers of the lung, esophagus, oral cavity, and pharynx.

The CDC National Center for Health Statistics provides the following age-adjusted death rates for lung cancer per 100,000 persons between 1997–2001, as shown in Table 3. ***The average age-adjusted death rates for lung cancer per 100,000 persons, during the period 1997–2001 was 55.9 for Blacks, 50.5 for Whites, and 21.4 for Hispanics.***

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<sup>12</sup> Connecticut Department of Public Health, Policy, Planning and Analysis. Looking Toward 2000-State Health Assessment. Available at <http://www.dph.stste.ct.us>

**Table 3: Lung Cancer per 100,000 Persons: 1997–2001**

	<b>Connecticut</b>	<b>National</b>
Overall	50.5	56.2
White	50.5	56.2
Black	55.9	65.2
Hispanic	21.4	24.9
Asian/Pacific Islander	15.7	28.2
American Indian/Alaska Native	---	36.3

**Source: Center for Disease Control 2002.**

- **Children**

In many cases, there are only small differences between the races in terms of the prevalence of health conditions. However, there are differences in terms of general health, asthma, respiratory allergies, and children’s level of physical activity, as shown in Table 4. Black, multiracial and Hispanic children were worse than white children. Most notably, the prevalence of asthma is much higher in multiracial and Hispanic children than in White children and is somewhat higher in black children. Of concern is the fact that black, Hispanic, and multiracial children are less likely than white children to be physically active for 20 or more minutes on three or more days per week. This lack of physical activity can put children at risk for obesity, which in turn increases their risk for various chronic diseases.



<b>Table 4: Prevalence of health conditions in children age 0–17 in CT, 2003–2004, (% yes)</b>					
	<b>White</b>	<b>Black</b>	<b>Multiple Races</b>	<b>Other</b>	<b>Hispanic</b>
<b>General Health Status</b>					
Excellent	1144 (73.0)	80 (59.4)	36 (57.9)	46 (70.4)	90 (50.0)
Very good	300 (19.1)	30 (22.3)	11 (23.2)	17 (20.0)	39 (23.6)
Good	96 (7.3)	19 (14.2)	7 (16.4)	5 (6.0)	25 (18.9)
Fair	11 (0.6)	3 (4.2)	2 (-)	2 (-)	8 (6.9)
Poor	1 (-)	0 (-)	0 (-)	0 (-)	1 (-)
Limitations due to health	64 (4.0)	6 (5.4)	7 (15.6)	0 (0.0)	12 (6.4)
Needs prescribed medication	337 (20.7)	22 (18.6)	15 (28.1)	8 (12.8)	33 (17.6)
Learning disability	129 (9.1)	8 (6.4)	1 (-)	1 (-)	23 (16.0)
ADD/ADHD	100 (6.5)	3 (2.5)	8 (27.1)	0 (0.0)	9 (6.0)
Autism	9 (0.5)	0 (-)	1 (-)	0 (-)	1 (-)
Developmental delay or physical impairment	58 (3.4)	5 (3.4)	3 (-)	1 (-)	8 (3.8)
Depression/anxiety	60 (4.0)	4 (4.5)	5 (18.3)	1 (-)	12 (7.9)
Asthma	180 (11.6)	20 (14.4)	13 (24.3)	5 (9.5)	35 (23.4)
Bone/joint/muscle problems	48 (2.8)	2 (2.5)	5 (8.2)	3 (4.7)	8 (3.9)
Diabetes	2 (-)	1 (-)	0 (-)	0 (-)	1 (-)
Respiratory allergies	226 (14.5)	13 (7.9)	16 (25.9)	6 (10.1)	19 (8.9)
Food/digestive allergies	81 (5.4)	8 (4.5)	2 (-)	2 (-)	10 (6.1)
Physically active on 3 or more days per week (3–7)	774 (74.0)	56 (62.4)	24 (65.6)	26 (74.7)	62 (61.8)

**Source: Connecticut Department of Public Health – Vital Statistics 2005.**

- **Health Conditions in Connecticut among age 18 and over, 2000–2004**

Table 5 shows the prevalence of certain key disorders among members of various racial groups living in Connecticut. Compared with Whites, Blacks and Hispanics were more likely to be in fair or poor health, based on a standard question about general health. *The probability for fair or poor health among Blacks as compared with Whites was 1.33, and for Hispanics compared with White, the probability was 2.25.*

<b>Table 5: Health conditions in CT residents age 18 and over, 2000–2004 (% yes)</b>				
	<b>Black/African American</b> N (%) N = 1,189	<b>White/Caucasian</b> N (%) N = 20,898	<b>Hispanic</b> N (%) N = 4,085	<b>Other Groups</b> N (%) N = 808
<b>General health status</b>				
Excellent	261 (23.3)	5803 (28.0)	290 (21.3)	235 (29.0)
Very good	320 (26.2)	7543 (36.5)	336 (20.1)	241 (29.2)
Good	403 (36.0)	5140 (24.6)	504 (34.7)	240 (30.2)
Fair	146 (10.4)	1719 (7.9)	282 (20.0)	63 (8.5)
Poor	51 (3.7)	627 (2.7)	70 (3.9)	24 (2.4)
Asthma	182 (14.0)	2691 (13.0)	279 (16.0)	109 (12.6)
Diabetes	94 (8.7)	968 (6.0)	74 (4.5)	36 (5.0)
Gestational diabetes (during any pregnancy)	14 (1.4)	202 (1.1)	27 (1.6)	14 (1.9)
Prostate Cancer	11 (3.7)	185 (3.8)	4 (1.8)	6 (2.0)
Hysterectomy	51 (12.6)	1040 (16.5)	42 (10.4)	10 (6.2)
Hypertension	178 (32.0)	2678 (26.3)	122 (15.4)	50 (14.0)
Ever had heart attack	5 (2.0)	135 (3.1)	5 (1.0)	4 (1.8)
Had stroke	6 (1.9)	70 (1.5)	3 (0.8)	4 (2.0)
Angina or CHD	5 (1.9)	176 (4.2)	7 (2.4)	7 (4.2)
Arthritis	187 (21.4)	4323 (27.4)	183 (13.9)	75 (13.1)
High Cholesterol	128 (23.4)	2992 (31.1)	141 (24.6)	92 (24.1)
<i>Not all questions were asked in all years of the survey or of all age/sex groups. Not adjusted for age or other potential confounders.</i>				

Source: Center for Disease Control – Behavioral Risk Factor Surveillance System (BRFSS) 2005.

**“We need to focus on the uninsured and those who suffer from health care disparities that we so inadequately addressed in the past.”**

**Sen. Bill Frist (R-Tennessee.)  
Senate Majority Leader  
108th Congress**

## VI. HEALTHCARE COVERAGE AND UTILIZATION

There were differences between the racial and ethnic groups in Connecticut with regard to the number of people who had health coverage. As shown in Table 6, compared to Whites, the probability of being uninsured among Blacks was 2.79 times higher, and among Hispanics, 4.45 times higher. *In general, most people were able to get the care they needed, but 7.1% of Whites, 15.5% of Blacks, 18% of people of other races, and a full 22.4% of Hispanics were unable to get needed care because of cost.* There were also differences in the proportion of people who had a person they considered their personal doctor or healthcare provider. *In general most people had at least one personal doctor or healthcare provider, except for 29% of Blacks, 19.5% of Whites, 41.5% of Hispanics, and 30.9% of people of other races.* Having a provider one thinks of as his or her personal doctor is important because it indicates that such a person has a “medical home,” a place where he/she can receive comprehensive care. This is important for both disease and disability prevention, and also for the management of existing chronic diseases.

<b>Table 6. Healthcare coverage and utilization in CT residents age 18 and over, 2000–2004 (% yes)</b>				
	<b>Black/African American</b> N (%)	<b>White/Caucasian</b> N (%)	<b>Hispanic</b> N (%)	<b>Other Groups</b> N (%)
Any health coverage	995 (80.5)	19529 (92.8)	1138 (67.4)	703 (84.2)
Have personal doctor/provider				
Yes, 1	1725 (71.0)	17080 (80.5)	1001 (58.5)	578 (69.1)
Yes, more than 1	106 (8.4)	1725 (8.3)	83 (5.1)	55 (6.6)
<b>Where go when sick or in need of health advice</b>				
Doctor's office	157 (63.2)	4083 (84.6)	171 (46.2)	112 (68.1)
Clinic	28 (11.9)	168 (3.4)	53 (20.5)	15 (12.5)
Hospital—outpatient	12 (3.4)	70 (1.6)	26 (8.5)	7 (5.5)
Hospital ER	25 (14.2)	103 (2.2)	37 (9.3)	7 (4.8)
Urgent care	3 (0.8)	52 (1.1)	4 (1.5)	1 (0.3)
Other	5 (1.7)	104 (2.5)	3 (1.3)	5 (1.9)
None (8)	10 (4.3)	172 (4.5)	27 (11.9)	8 (6.4)
Needed care but couldn't get it because of cost	82 (15.5)	653 (7.1)	130 (22.4)	52 (18.0)

Source: Center for Disease Control – Behavioral Risk Factor Surveillance System (BRFSS) 2005.

**“With greater frequency than other Americans, preventable illnesses take a terrible toll on racial and ethnic minority communities, and African Americans are dying prematurely as a consequence.”**

**Bishop T. D. Jakes, Founder and Senior Pastor  
The Potter’s House**

## VII. PREVENTABLE HOSPITALIZATION

Overall, timely outpatient care and disease management (e.g., regular healthcare visits, diagnostics, pharmaceuticals, and appropriate behaviors) limit the severity of ACSCs and thereby “prevent” or at least reduce the need for hospitalization. Therefore, preventable hospitalization volume highlights the possibility of gaps in the primary care health system, disease management (both by the provider and by the patient), and access to health services that have led to the escalation in disease severity and, ultimately, hospitalization. In FY 2004, there were more than 50,000 “preventable hospitalizations” of Connecticut residents with nearly 300,000 total patient days and total associated charges of approximately \$ 1 billion dollars.

It is the general consensus that timely outpatient care and disease management limit the severity of Ambulatory Care Sensitive Conditions (ACSC’s) and thereby prevent the need for hospitalization. *The ACSC total charges in Connecticut increased from \$611 million to \$893 million (46.2%) during FY period 2000-2004 as shown in Table 7. Minorities accounted for over half of the recent increase in ACSC hospitalizations. Compared with all races combined, Blacks had higher rates for 11 of the 16 ACSCs, meaning they were more likely to be hospitalized for these conditions. Blacks had rates twice as high as or greater than all races combined for adult and pediatric asthma, all diabetes conditions, hypertension and lower extremity amputations. Based upon this data, it is estimated that 2008 ACSC charges will exceed \$1.1 billion.*

Current statistics for 31 hospitals operating in Connecticut revealed that the average age at which Blacks were hospitalized for chronic diseases such as hypertension, diabetes, and cancer was 51

years of age as compared to 65 years of age for Whites and 59 years of age for Hispanics, as illustrated in Table 8.

Blacks and poorer patients have higher rates of avoidable hospitalizations (i.e., hospitalization for health conditions that, in the presence of comprehensive care, rarely require hospitalization). Higher rates of avoidable admissions for Blacks and lower socio-economic position persons may be explained, in part, by lower receipt of routine care by these populations.<sup>13</sup>

A high percentage of African Americans use hospital emergency rooms for healthcare needs. For some this becomes their comprehensive healthcare system. This trend has serious implications not only for those African Americans using emergency room facilities as a means of primary care, but also for the hospital system that must bear the cost of those unable to pay.

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<sup>13</sup> Agency for Healthcare Research and Quality, National Healthcare Disparities Report: Differential access may lead to disparities in quality, 2003, <http://www.ahrq.gov>



<b>ACSC Conditions</b>	<b>FY 2004 total charges (\$)</b>	<b>Total charge change (%) FY 2000 - 2004</b>	<b>Average charge (\$)</b>	<b>Average charge change (%) FY 2000 - 2004</b>
Adult Asthma	34,596,494	56.3	11,524	30.5
Angina	8,629,143	-23.8	10,116	35.7
Bacterial Pneumonia	196,722,535	41.8	16,077	28.8
Chronic Obstructive Pulmonary Disease	69,813,556	3.2	15,300	18.4
Congestive Heart Failure	212,320,641	56.9	19,218	48.4
Dehydration	42,764,095	47.4	10,240	23.0
Diabetes Long Term Complication	69,046,896	58.5	24,633	42.0
Diabetes Short Term Complication	14,835,993	25.2	13,176	8.3
Diabetes Uncontrolled	1,771,198	23.8	9,037	27.0
Hypertension	6,815,085	75.6	10,421	24.9
Low Birth Weight	132,536,199	61.3	48,125	54.8
Lower Extremity Amputation	44,507,518	46.6	44,154	57.8
Pediatric Asthma	8,580,327	40.3	6,103	37.7
Pediatric Gastroenteritis	2,989,681	72.8	6,152	49.7
Perforated Appendix	21,231,981	60.7	21,889	36.3
Urinary Tract Infection	53,188,423	78.9	12,433	35.8
<b>Total</b>	<b>\$892,882,657</b>	<b>46.2</b>	<b>-</b>	<b>-</b>

**Source: CT Office of Health Care Access, September 2005**

<sup>1</sup>Total charges are presented without double counting patients with more than one ACSC. They are, however, included within the total charges of each condition.

**Table 8: Average age for Blacks hospitalized for an ACSC by hospital, FYs 2000 - 2004**

Hospital	Diabetes Short TrmComp	Perforated Appendix	Diabetes Long TermComp	Pediatric Asthma	COPD	Pediatric Gastroenteritis	Hypertension	Congestive Heart Failure	Dehydration	Bacterial Pneumonia	Urinary Infection	Angina	Diabetes Uncontrolled	Adult Asthma	Lower Extremity Amp
Bradley	.	.	.	.	.	.	.	71.8	75.7	68.0	38.8	49.3	51.0	38.5	.
Bridgeport		29.1	59.4	5.7	67.6	3.6	53.4	61.0	41.5	47.7	38.6	62.0	49.3	43.7	65.4
Bristol	41.0	40.0	65.2	17.0	83.1	.	67.5	61.3	68.7	50.5	60.6	56.0	59.8	43.3	64.3
CCMC	18.0	10.4	.	6.0	.	2.1	.	.	4.3	5.8	5.0	.	.	.	.
C.Hungerford	48.3	.	57.0	3.8	61.0	.	.	59.3	27.0	46.8	77.2	.	37.5	46.0	.
Danbury	47.5	47.9	49.6	8.5	68.5	0.3	58.7	61.9	55.0	49.2	63.7	59.5	50.5	37.5	63.5
Day Kimball	51.0	.	64.0	7.3	61.1	.	39.0	.	53.0	50.4	83.0	50.0	52.0	40.0	.
Greenwich	44.8	34.0	64.5	7.5	75.4	5.7	52.6	66.9	48.7	39.6	66.5	68.8	63.3	51.1	59.0
Griffin	40.2	.	65.2	.	71.8	.	42.1	63.3	64.6	54.4	42.2	60.2	.	38.3	72.7
Hartford	49.9	49.6	58.2	17.0	63.3	17.0	55.0	63.8	60.8	56.7	58.4	61.5	56.5	46.8	62.8
John Dempsey	33.2	29.3	62.2	.	59.4	.	47.8	57.9	50.9	52.2	48.5	46.3	54.7	42.2	59.5
Johnson	53.0	.	58.0	.	63.3	.	.	63.7	0.0	44.5	54.3	55.3	55.5	22.5	.
L & M	42.9	25.2	58.0	4.4	66.4	4.0	52.2	60.0	48.4	50.8	62.9	58.6	50.8	48.6	62.4
Manchester	39.5	39.0	50.8	10.5	67.7	0.0	49.0	59.7	54.1	51.4	55.8	54.6	51.9	48.7	41.0
Middlesex	55.5	23.0	64.4	0.0	64.0	.	52.5	62.0	55.1	55.1	65.7	61.9	55.7	42.5	66.4
MidState	43.4	40.0	61.1	10.0	57.0	.	48.9	60.7	59.7	53.0	42.5	63.8	18.0	42.7	56.0
Milford	34.0	83.0	54.6	.	72.5	13.0	55.5	78.3	92.0	69.8	76.7	59.8	46.0	63.8	42.0
New Britain	42.8	33.2	58.7	5.9	67.1	4.8	53.2	65.0	50.5	49.5	57.4	60.5	46.1	43.3	59.0
New Milford	46.5	45.0	64.0	6.0	70.5	.	.	64.5	65.0	49.7	.	65.0	43.0	51.0	.
Nowalk	48.4	36.9	60.5	5.3	66.7	2.8	55.8	66.3	46.4	51.9	57.1	58.4	55.9	52.9	66.6
Rockville	32.0	37.0	63.8	10.0	81.5	.	59.5	64.4	63.0	60.6	55.5	68.7	60.5	47.5	66.5
Sharon	69.3	.	68.0	5.1	.	.	.	68.1	70.0	46.1	.	71.5	.	.	.
St. Francis	45.4	40.4	59.2	5.1	67.1	3.6	50.6	64.8	53.7	55.7	57.5	60.9	57.1	49.4	66.2
St. Mary's	42.8	29.0	62.3	5.5	66.7	1.7	54.1	67.5	39.9	50.6	54.8	53.5	64.7	43.0	68.1
St. Raphael's	55.8	48.7	67.8	8.1	72.9	9.6	68.5	78.4	72.4	76.7	76.5	64.9	67.5	58.1	68.7
St. Vincent's	46.4	31.8	56.2	6.6	64.6	6.5	54.7	63.2	65.9	60.3	62.0	57.7	55.1	45.8	65.1
Stamford	51.6	33.2	62.0	6.2	69.7	5.8	50.6	67.1	44.8	49.8	56.6	62.4	55.1	56.5	64.3
Waterbury	43.8	33.7	52.9	6.1	64.6	4.6	49.0	61.8	40.6	50.6	43.5	52.1	47.4	47.3	67.7
William Backus	45.0	30.3	52.3	7.2	64.9	3.7	45.6	60.3	45.6	43.0	58.0	57.3	53.7	36.5	52.1
Windham	21.2	17.0	45.0	4.2	60.7	5.7	38.5	59.8	37.1	52.3	44.5	67.0	46.7	42.3	.
Yale	41.4	31.7	57.8	7.1	65.3	3.4	52.6	61.0	42.2	45.8	49.0	57.7	51.6	43.5	59.9

Source: CT Office of Health Care Access Inpatient Acute Care Hospital Discharge Database.

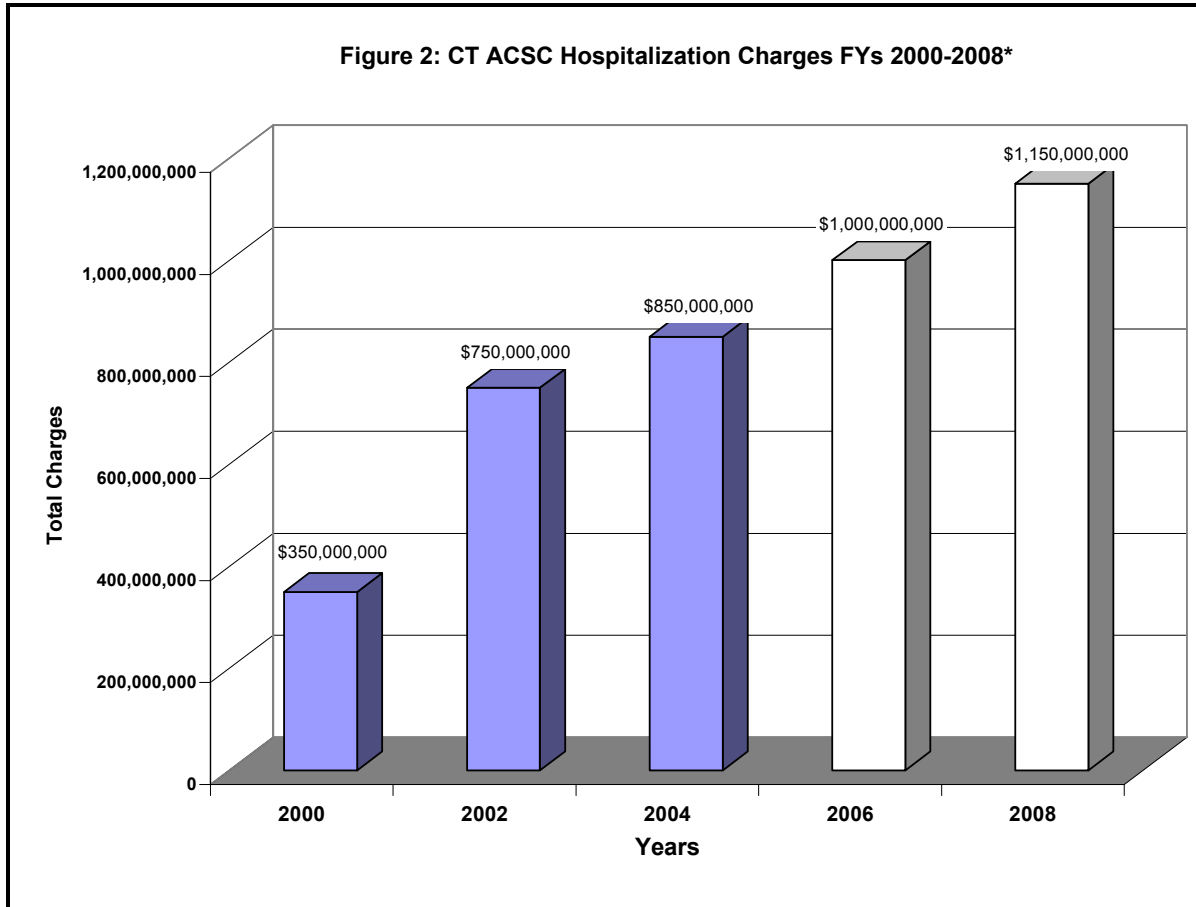
Average age difference between Blacks and Whites Hospitalized within the same ACSC.

Color Code

5 -10 years



10 + years



*2006 and 2008 reflect projected increases and have been adjusted for inflation.*

**Source: Connecticut Office of Health Care Access, September 2005**

*Avoidable hospitalizations are a good example of the link between access and disparities in quality of care.* These hospitalizations may reflect, in part, the adequacy of primary care. When healthcare needs are not met by the primary healthcare system, rates of avoidable admissions may rise.<sup>14</sup> Connecticut's emergency room usage is slightly higher than the national rate (420, visits per 1,000 populations, in the state of Connecticut, compared with 400 nationally).

<sup>14</sup> Agency for Healthcare Research and Quality. National Healthcare Disparities Report: Differential access may lead to disparities in quality, 2003, <http://www.ahrq.gov>

Emergency room use has increased by approximately 7% since 2001 to a total of nearly 1.5 million visits in 2004.<sup>15</sup>

Hospitalizations may be prevented when clinicians effectively diagnose, treat, and educate patients, and if patients actively participate in their care and adopt healthy lifestyle behaviors.<sup>16</sup>

Potentially preventable hospitalizations are a significant issue in regard to both quality and cost.<sup>17</sup> **Residents from areas with the lowest incomes (less than \$25,000) have the highest rates of admission for all preventable hospitalizations. The greatest amount of variation occurs for (1) uncontrolled diabetes without complications and short-term diabetes complications, (2) hypertension, and (3) adult asthma.**<sup>18</sup>

*Black and Hispanic Connecticut residents have significantly higher rates of hospitalizations for diabetes and for lower-extremity amputations than do White residents (p <0.05 for both comparisons). Black residents have 3.8 times the rate of diabetes hospitalizations and 3.6 times the rate of lower extremity amputations due to diabetes when compared with White residents. Hispanics have 2.5 times the rate of diabetes hospitalizations and 3.2 times the rate of lower-extremity amputations due to diabetes when compared with White residents (p <0.05 for both comparisons).*

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<sup>15</sup> Connecticut Healthcare System-Access, Delivery, Quality, and Health Promotion, Robin Cohen, Principal Analyst

<sup>16</sup> Healthcare Cost and Utilization Project (HCUP). Preventable Hospitalizations: Window Into Primary and Preventable Care, 2000, <http://www.ahrq.gov>

<sup>17</sup> Healthcare Cost and Utilization Project (HCUP). Preventable Hospitalizations: Window Into Primary and Preventive Care, 2000, <http://www.ahrq.gov>

<sup>18</sup> Healthcare Cost and Utilization Project (HCUP). Preventable Hospitalizations: Window Into Primary and Preventable Care, 2000, <http://www.ahrq.gov>

ACSC Conditions	Rate per 100,000 people				
	Black	Hispanic	Other	White	All Races
Adult Asthma	264.5	261.0	75.1	82.7	113.3
Angina	28.3	17.7	25.7	34.5	32.2
Bacterial Pneumonia	285.8	239.0	206.1	381.8	351.3
Chronic Obstructive Pulmonary Disease	97.6	60.8	54.4	198.1	172.2
Congestive Heart Failure	550.6	261.0	205.6	430.1	416.9
Dehydration	112.4	86.1	90.8	126.8	119.9
Diabetes Long Term Complication	263.2	118.6	70.2	89.4	105.8
Diabetes Short Term Complication	143.5	71.2	20.8	29.6	42.5
Diabetes Uncontrolled	26.1	12.1	5.9	5.0	7.4
Hypertension	89.1	21.6	23.7	18.2	24.7
Low Birth Weight	11.1	7.4	5.8	5.8	6.6
Lower Extremity Amputation	83.2	44.4	23.7	33.2	38.0
Pediatric Asthma	389.1	304.0	205.0	100.8	168.8
Pediatric Gastroenteritis	65.0	94.1	66.1	49.1	58.3
Perforated Appendix	25.8	22.2	21.8	25.1	24.6
Urinary Tract Infection	113.0	100.9	85.3	128.9	122.8

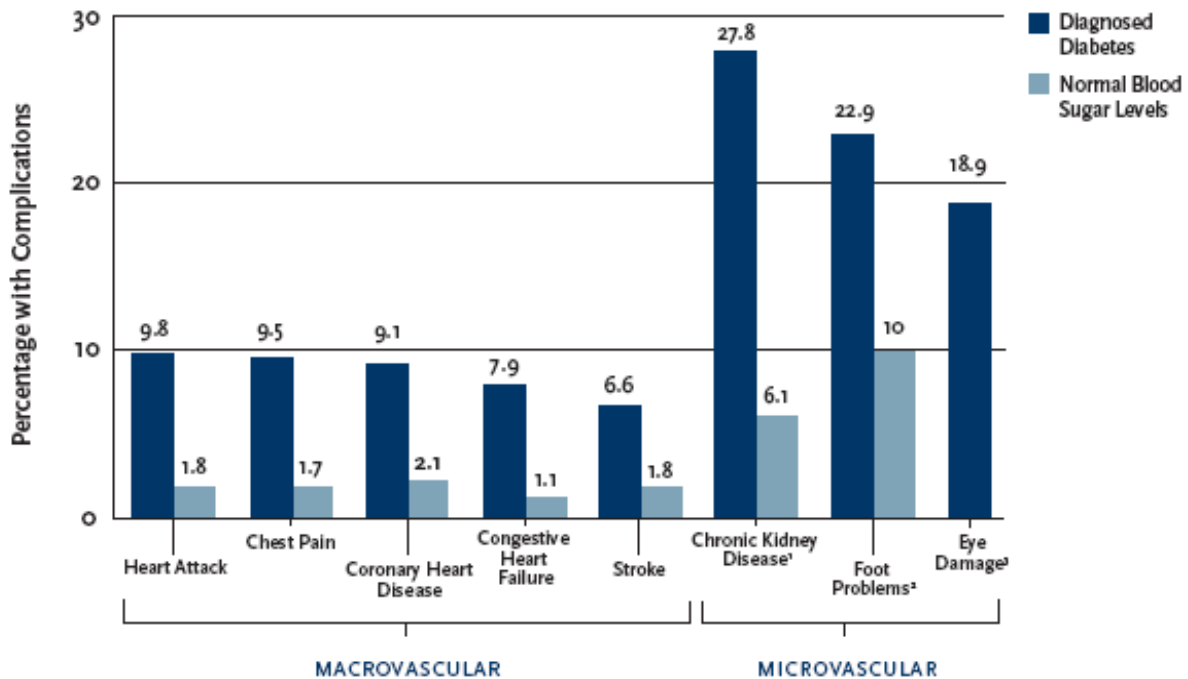
**Source: Connecticut Office of Health Care Access, September 2005**

The direct (medical care) and indirect costs (lost productivity and premature mortality) of diabetes alone in Connecticut were estimated at \$1.7 billion in 2003. This estimate includes direct medical costs and indirect costs associated with lost productivity from illness and death. Diabetes can accrue enormous indirect costs. It is a major cause of disability and the inability to live independently, and can severely impact the quality of life for individuals and families. Approximately \$77 million was billed for hospitalizations in Connecticut due to diabetes as a principal diagnosis in 2002. Almost \$39 million was billed for hospitalizations related to diabetes with a lower extremity amputation.

**Additionally, these individuals who suffer from diabetes are likely to have kidney complications known as End Stage Renal Disease (ESRD). The two leading causes of ESRD**

are uncontrolled hypertension and uncontrolled diabetes. African Americans are over represented in the ESRD population and therefore are at higher risk for these diseases. African Americans represent 30.2% of the dialysis population in Connecticut as compared to 69.8% of the white population. The annual ESRD cost per patient approximates \$90,000. To further understand and appreciate the impact of disparities and health inequities one only has to view the other down stream sequela of Diabetes were almost 30% of those with complications will suffer from eye damage and 9.8% will potentially have a heart attack and almost 30% will have foot problems and may require amputations.

Figure 3: Prevalence of Diabetes Macrovascular & Microvascular Complications



Source: "A Comprehensive Report issued by the American Association of Clinical Endocrinologists".

**"Culture plays a major role in the provision of quality  
healthcare and the culture of medicine is predominately  
white European."**

**David M. Satcher, M.D., Ph.D.  
16th Surgeon General of the United States**

## VIII. CULTURAL EXPERIENCE

Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). It refers to the shared attributes of one group. Anthropologists often describe culture as a system of shared meanings. The term “culture” is as applicable to the white race as it is to racial and ethnic minorities.<sup>19</sup>

More often, culture comes to bear upon whether people even seek help in the first place, what types of help they seek, what coping styles and social support they have, and how much stigma they attach to an illness. All cultures also feature strengths, such as resilience and adaptive ways of coping, which may buffer some people from developing certain disorders.<sup>20</sup>

The dominant culture for much of United States history focused on the beliefs, norms, and values of European Americans. But today’s America is unmistakably multicultural. And because there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation, or profession), many people consider themselves as having multiple cultural identities.<sup>21</sup>

***Sociocultural factors are a root cause of healthcare disparities because they have an impact on health beliefs, behaviors, and treatments.*** These factors affect: variation in symptom

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<sup>19</sup> U.S. Department of Health and Human Services. Office of the Surgeon General, Main Message: Culture Counts, SAMHSA

<sup>20</sup> U.S. Department of Health and Human Services. Office of the Surgeon General, Main Message: Culture Counts, SAMHSA

<sup>21</sup> U.S. Department of Health and Human Services. Office of the Surgeon General, Main Message: Culture Counts, SAMHSA



presentation, expectations of care, bias, mistrust, prejudice, stereotyping, and ability to maneuver within the system.<sup>22</sup>

## **Health Professionals**

Culture is a concept not limited to patients. It also applies to the professionals who treat them. Every group of professionals embodies a “culture” in the sense that they to have a shared set of beliefs, norms, and values. This is as true for health professionals as it is for other professional groups such as engineers and teachers.<sup>23</sup>

To say that physicians and health professionals have their own culture does not detract from the universal truths discovered by their fields. Rather, it means that most clinicians share a worldview about the interrelationships between body, mind, and environment informed by knowledge acquired through scientific methods. *Clinicians view symptoms, diagnoses, and treatments in ways that sometimes differ from the clients’ views, especially when the cultural backgrounds of the consumer and provider are dissimilar.* This difference of viewpoints can create barriers to effective care.<sup>24</sup>

The culture of the clinician and the larger healthcare system govern the societal response to a patient and influence many aspects of the delivery of care, including diagnoses, treatments, and the organization and reimbursement of services. *Clinicians and service systems, naturally*

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<sup>22</sup>U.S. department of Health and Human Services. Agency for Healthcare Research and Quality. Strategies to Reduce Health Disparities. Presenter: Joseph R. Betancourt, M.P.H., M.D., Senior Scientist, Institute for Health Policy. Available at <http://www.ahrq.gov>

<sup>23</sup> U.S department of Health and Human Services. Office of the Surgeon General. Surgeon General’s Report, Main Message: Culture Counts, SAMHSA

<sup>24</sup> Ibid.

*immersed in their own culture, have been ill equipped to meet the needs of patients from different backgrounds and, in some cases, have displayed bias in the delivery of care.*<sup>25</sup> For many families the cumbersome route, often involving several bus changes with children, to access care makes it daunting. Compounded for these individuals is being turned away when they arrive late, or being labeled noncompliant if they fail to arrive.

### **African American Community**

Race was cited as a factor, by the focus groups, in health disparities. The historical experiences of native African Americans with respect to health issues, which span several generations, contribute in some measure to attitudes that exist today. As a result, an attitude of mistrust looms among Connecticut's African American population, which influences health decisions. *How healthcare is delivered and by whom it is delivered are important factors, given the historical cultural experience of Connecticut's African American population.*

Generally, information is transmitted mostly by word of mouth in the Black community even in today's technology and information-driven world. The most common places that this occurs are in barbershops, in beauty salons, on street corners, and at funerals. This leads to health information circulating among African Americans based on hearsay rather than facts. What has emerged over time is a "hearsay culture" that is considered reliable and adequate. It is estimated that about 70% of Connecticut's African American population relies on hearsay.

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<sup>25</sup> U.S. Department of Health and Human Services. Office of the Surgeon General, Surgeon General's Report, Main Message: Culture Counts, SAMHSA

*The legacy of the infamous Tuskegee experiment of the 1930s has lingered in the consciousness of African Americans and, consequently, a fear factor is etched in the subconsciousness of Connecticut's African Americans relative to health matters. Fear produces barriers that can prevent one from making intelligent decisions. This is significant when we see that African Americans are underrepresented in clinical research trials for new drugs.*

*This suggests that some health disparities are internally driven in the Black community. The high death rate from prostate cancer among African American men can be traced, largely, to a lack of early detection and a reluctance to undergo the necessary preventive measures because of fear or religious beliefs.* This has great significance for Connecticut given the fact that two of the world's largest pharmaceutical drug companies are located in the state.

Misinformation about AIDS, fueled by hearsay, has been a significant factor in this disease reaching epidemic levels in the black community. These barriers can prevent early detection, which is considered a key factor in preventing serious illnesses. Very often, these barriers are passed on from adults to offspring. These are indicators of the impact that culture has on matters of health in Connecticut's black community

## IX. SOCIO-ECONOMIC DYNAMICS

*Without question the income disparity between rich and poor in Connecticut, which continues to widen, is a major contributor to health disparities for Connecticut's African American population. A major determinant of health and longevity is one's socio-economic status. The lower one is on the socio-economic ladder the greater the possibility of poor health and death at an early age. Socio-economic status can produce the conditions in which individuals become more susceptible to a variety of illnesses. It is important to note that poverty is an economic condition and not a health condition. Poverty is a root cause of racial and ethnic healthcare disparities and requires an economic solution.*

In Connecticut, poverty is concentrated in the Urban Core and exceeds the national average. In 2000, the rate of poverty in the Urban Core was 1.6 times the national average. Extreme poverty in the Urban Core was 1.8 times the national average. The rate of families in poverty was 1.9 times the national average. *And the rate of children in poverty in the Urban Core was 1.7 times the national average. In 2000, the Urban Core accounted for only 18.8% of the state's population but 48% of the state's population living in poverty. The state has too much concentrated disparity to be viewed in average terms.*<sup>26</sup>

Socio-economic conditions in the Urban Core were extremely stressed during the 1990s. Between 1990 and 2000, the population of the Urban Core grew by 125,643, or 24%. In 2000,

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<sup>26</sup> University of Connecticut, Center for Population Research. The Changing Demographics of Connecticut-1990 to 2000. Part 2, The five Connecticut, 2004. Available at <http://www.popcenter.uconn.edu>

the poverty rate was 19.4% as compared with a statewide average of 7.6% and a national average of 12.1%. *Also in 2000, 29% of all children in the Urban Core lived in poverty.*<sup>27</sup>

Persons living in poverty are considerably more likely to be in fair to poor health and to have disabling conditions. *In addition, they are less likely to have the types of health care associated with those having incomes equal to 200% of the poverty line or higher.*<sup>28</sup> *Socio-economic and cultural differences among racial and ethnic groups in the United States will likely continue to influence patterns of disease, disability, and healthcare use.*<sup>29</sup>

The ability to pay does not necessarily translate into adequate health care. Statistical data indicate that black citizens are hospitalized at a significantly earlier age than their white counterparts for chronic illnesses such as hypertension and congestive heart failure. There are many African American professionals in Connecticut in upper-middle and high income levels who have excellent fringe benefit packages. Yet, many individuals in these income levels experience excessive morbidity and mortality before reaching retirement. They spend their time and money enjoying the fruits of their success (a product of the civil rights struggles) during their productive working years and in the process they delay obtaining routine health examinations.

*The personal cost of disparities can lead to significant morbidity, disability, and lost productivity at the individual level.*<sup>30</sup>

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<sup>27</sup> University of Connecticut, Center for Population Research: The Changing Demographics of Connecticut-1990-2000, Part 2, The Five Connecticuts, 2004, <http://www.popcenter.unconn.edu>

<sup>28</sup> U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics: Health, United States, 2006, Library of Congress Number 76-641496, 5 pp

<sup>29</sup> U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics: Health, United States, 2006, Library of Congress Number 76-641496, 5 pp

<sup>30</sup> Agency for Healthcare Research and Quality: National Healthcare Disparities Report, 2003, <http://www.ahrq.gov>

## **X. LEGISLATIVE IMPACT**

Our extensive research, which was conducted to determine the legislative impact on healthcare disparities among Connecticut's African American or Black population, revealed that bills passed by the General Assembly between 1998 and 2006 concerning health issues were not race or ethnic specific. This is also the case for current bills proposed during the 2007 General Assembly. This would indicate that policy makers have not separated the healthcare issues experienced among Connecticut's African American population from healthcare issues experienced by the general population. As a result, intended or unintended consequences of legislation may impact health disparities within Connecticut communities.

Since 2003, key essential services such as podiatry, vision care, and transportation for certain non-emergency medical services were reduced or eliminated under the State-Administered General Assistance Program (SAGA). For example: Reductions SAGA, under funding Dental Services, podiatric services, constantly and consistently under funding Medicaid that significantly limits access and provider engagement. This is a vital health insurance program for the state's poorest men and women, many of whom suffer from chronic and acute medical conditions.

Low-income minority communities are in greater need of low-cost health coverage as a result of disparities in access and care. A person who has to switch doctors or who cannot access critically needed services like vision care or podiatry services may not be able to prove a claim of disability based on severe eye disorders or diabetes. African American communities are twice as likely to suffer from diabetes and its resultant podiatric, ophthalmologic, and kidney

complications. Bill no. HB-6927 was introduced by the Human Services Committee in March 2005 to restore SAGA.

SAGA Medical, HB-6927, would have restored services to the SAGA Medical program and removed the program-funding cap. This bill was not successful but the budget did allocate **\$500,000** for a 100-person pilot for 18 to 21 year olds who have a diagnosis of mental illness and a chronic health condition, who live with parents or caretakers, and who have income that would make them ineligible for SAGA Medical. Individuals are presumed to be waiting for SSI disability approvals during the period of eligibility.

*Information obtained from the Connecticut General Assembly indicated that from 2001 to early 2007 a total of 93 health-related bills were introduced in the legislature. Our analyses of these bills revealed that 66 (71%) of the bills were never enacted; 10 (11%) bills were enacted; 16 bills are currently pending, and 1 bill was changed. This raises a question. Why was such a high percentage of health-related bills not enacted?*

*There is some concern when well-intentioned, financial and/or legislative initiatives create indirect or unintended consequences. For example, a reduction of podiatric services, which involve foot care, can generate a disproportionate reduction of podiatric treatments. This, in turn, can lead to a disproportionate increase in lower extremity amputations—an unintended consequence.*

*Other example of Legislative short coming are the under funding of dental care services for Medicaid eligible children and the lack of support through the Legislative process for family and individuals impacted by Sickle Cell Disease.*

Several bills have been introduced to Connecticut's 2007 General Assembly intended to close the healthcare gap. These bills, if enacted in their current form, would not fully address the root causes of racial and ethnic disparities that exist in Connecticut. *What is needed is a comprehensive healthcare bill with specific purposes, goals, objectives, strategies, timelines, and funding. The climate appears to be right at this time for a concerted effort to make this the number one priority of the state's policy makers.*



## **XI. FUTURE CHALLENGES**

This report is limited, in time and space, in addressing the many medical conditions that are worthy of comment. Included in this group are childhood diabetes, sickle cell anemia, oral health, lead poisoning, lifestyle behaviors, and HIV-AIDS, to mention only a few:

### **Environmental Factors**

Air pollution kills more Americans than breast and prostate cancer combined, and premature deaths associated with particulate matter pollution alone are comparable to deaths from traffic accidents.<sup>31</sup> Air pollution is a serious and growing threat to the health of urban minorities in Connecticut. We estimate that nearly one million of Connecticut's 3.5 million residents experience one or more of these illnesses, some without knowing it.<sup>32</sup>

### **Demographic Trends**

Demographic trends indicate that the number of Americans who are vulnerable to suffering the effects of healthcare disparities will rise over the next half century. Nearly 1 in 2 Americans will be a member of a racial or ethnic minority—i.e., black, Hispanic, Asian, or American Indian—by the year 2050. Clearly, these trends pose a daunting challenge for policy makers and the health care system.<sup>33</sup>

### **Youth Violence**

The serious nature of injuries is reflected in their status as the leading cause of death among individuals below 35 years of age. There is an emerging concern in communities across the

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<sup>31</sup> The Harmful Effects of Vehicle Exhaust: A Case for Policy Change. Environment & Human Health, Inc, John Wargo, Ph.D., Yale University, 2006

<sup>32</sup> The Harmful Effects of Vehicle Exhaust: A Case for Policy Change. Environment & Human Health, Inc, John Wargo, Ph.D., Yale University, 2006

<sup>33</sup> Agency for Healthcare Research and Quality: National Healthcare Disparities Report Summary, 2003, <http://www.ahrq.gov>

country regarding injuries resulting from youth violence. The majority of violent youths represent a disproportionate share of the victims.<sup>34</sup> In 2004, homicide continued to be the leading cause of death among black males 15–24 years of age.<sup>35</sup>

## **Rising Prison Population**

Historically prisons have been not places where healthy lifestyles are practiced. Connecticut's prison population has exceeded one million; of which nearly 50% are African Americans. Unhealthy lifestyles practiced in Connecticut's prisons generally are continued when ex-convicts are released from prison and return to society.

## **Obesity**

Obesity among Connecticut residents is increasing. It is the only factor consistently measured on the Behavioral Risk Factor Surveillance Survey (BRFSS) that has clearly worsened in Connecticut since 1989. Obesity is a risk factor for heart disease, stroke and high blood pressure; colon, breast, and prostate cancer; and diabetes.<sup>36</sup>

## **Internet**

Internet availability at home will be an important means of equitable access to health information among population groups. Clearly, the gap in health literacy is an issue that blocks fundamental fairness; closing this gap is essential to reducing health disparities. Inner-city neighborhoods in Connecticut are lagging in the percentage of homes having access to the Internet.

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<sup>34</sup> Connecticut Department of Public Health. Looking Toward 2000- State Health Assessment

<sup>35</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics: Health, United States, 2006, Library of Congress 76-641149

<sup>36</sup> Connecticut Department of Public Health. Looking Toward 2000-State Health Assessment; Obesity among African Americans has become an epidemic.

## **Mental Illness**

Mental illness in its various forms is a health issue that has not been vigorously examined in the Black community. The 2000 Surgeon General's Report on Mental Health revealed that mental illness is as prevalent among racial and ethnic minorities as among white populations. However, it is treated in a system that has little information about the cultural context in which these illnesses affect African Americans and their treatments.

Other emerging health issues, such as the impact of health education competency, will require a more in-depth review in the future.

**“I believe that there are reasons to be hopeful that with concerted efforts from the black community and other leaders, we will successfully reverse the current trends.”**

**David M. Satcher, M.D., Ph.D.,  
16th Surgeon General of the United States.**

## **XII. HEALTHCARE ACTIVISM**

The solution to this pervasive problem of health disparities is that we must advocate for system changes that include universal health insurance (one system), guaranteed primary medical care access, proportionate representation in health professions, bias-free interventions, nonviolent and exercise-friendly neighborhoods, nutritious food outlets, educational equality, career opportunities, parity in income and wealth, homeownership, and hope.<sup>37</sup>

*Currently, there is no unified, statewide, activist movement among Connecticut's African American population to address any of the prevalent health disparities identified in this report.*

However, there are groups throughout the state eager to be proactive on health-related matters if provided the information and proper training to become community health advocates. Sustainable proactive African American voices are critical for eliminating racial and ethnic healthcare disparities.

The one issue that is currently a major concern nationally is the rising cost of health care and the need for a universal healthcare system. Unfortunately, the means and the will to achieve a national universal healthcare system have been elusive. Individual states are attempting to find their own solutions. However, to date, only a few have managed to enact some legislation for this purpose. *Nothing has emerged that, if replicated, would meaningfully address the healthcare disparities that exist among Connecticut's African American population.*

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<sup>37</sup> Harvard Health Policy Review: Eliminating African American Health Disparity via History-based Policy, fall 2002, volume 3, number 2. Available at <http://www.hcs.harvard.edu/-epihc/currentissue/fall2002/Williams-Johnson-3.php>

**“Every American should have access to a full range of information  
about the quality and cost of their health-care options.”**

**Secretary Michael O. Leavitt,  
U.S. Department of Health and Human Services**

## **XIII. SUMMARY & CONCLUSIONS**

### **General**

Healthcare disparities among Connecticut's African Americans are long-standing conditions that have been inadequately addressed in the past. To date, the exact causes of racial and ethnic health disparities nationwide and in Connecticut have not been determined. What this Health Status Report does indicate is that the poor health status of Connecticut's African American population as compared with the white population, in accordance with the statistics, shows no signs of improvement over the first half of this decade. African Americans continue to lead in the prevalence of most chronic health illnesses reported.

There is absolutely no substitute for routine health examinations, started early in life, to address racial and ethnic healthcare disparities. *The major barriers that prevent this, for a substantial segment of Connecticut's African American population, are cost and resolve.*

There are complicated interrelationships between race, ethnicity, and socio-economic status that may result in healthcare disparities. While we may have sufficient data about racial disparities documented by race and by ethnicity, it is difficult to attribute the individual contributions of race, income, or education to these differences.

The following findings and conclusions are based on the examination of quantitative, qualitative, and legislative research data.

### **Race Ethnicity and Health in Connecticut**

This report, which covers health conditions in Connecticut residents age 18 and over for the period 2000–2004, reveals the following:

- Black and Hispanic mothers were more likely to bear low birth weight and premature babies.
- Black and Hispanic mothers were more likely to receive prenatal care late in pregnancy.

- Children of black mothers were more likely to experience premature deaths than children of white mothers.
- African American men have a higher risk of developing and dying from prostate cancer as compared with white males and Hispanic males.
- White women are slightly more likely to develop breast cancer than African American women. African American women are more likely to die from this cancer.
- African American women have a higher cervical cancer rate than white women.
- The prevalence of asthma is much higher among multiracial and Hispanic children than among white children and is somewhat higher in black children.
- Black, Hispanic, and multiracial children are less likely than white children to be physically active for 20 or more minutes on three or more days per week. This lack of physical activity can put children at risk for obesity, which in turn increases their risk of chronic diseases.
- Compared with Whites, Blacks and Hispanics were more likely to be in fair or poor health. Compared with Whites, Blacks are 1.99 times as likely to be obese and Hispanics are 1.40 times as likely. Again, this increases the risk for chronic diseases such as diabetes, hypertension, and cardiovascular disease.

### **African American Health Status Report: “Focus Group Research Final Report”**

*First, across all focus groups, the message was clear that the community-at-large is yearning for and demanding inclusion in and access to services that will improve their quality of life.*

They consistently stated that policy makers must address the communities’ needs on all levels. However, first and foremost, they must give more contextual support, i.e., encouragement, assistance, and rewarding reinforcement.

Second, it was the position of the group that they know there needs to be research, but there are ethical dilemmas about the manner in which the research is done. When more research is completed, it must be ethically sound and practical for the population being studied. The focus group argued that studies lack the following: (1) cultural competency, (2) specificity to the



population in crisis, (3) inclusion of communities' beliefs and value systems, and (4) dissemination of programs and policies to the communities.

Third, as far as programming, it was noted that: (1) layperson competencies must be valued and respected, (2) there must be cross-training of all stakeholders, (3) quick fixes no longer work; get rid of the "Band-Aid" and identify the sources of socio-economic issues and diffuse them, and (4) give the community back its "heart and soul," i.e., jobs, qualitative services, and self-respect. Truly embrace the universal declaration of health.

### **Hospitalization Statistics, 2000–2004**

In Connecticut, ACSC patients tend to require extensive healthcare resources, both within the hospital and following discharge: nearly two-thirds had been previously hospitalized, most were admitted through the Emergency Department (80%), and nearly half received additional care after discharge (25% transferred to another facility and 20% required home health services).

*Preventable hospitalizations are increasing in Connecticut. ACSC total charges in Connecticut increased from \$611 million to \$893 million (46.2%) during the period 2000–2004. Minorities accounted for more than half of this recent increase in ACSC hospitalizations. Blacks had higher rates for 11 of the 16 ACSCs, meaning they were more likely to be hospitalized for these conditions. Blacks had rates twice as high as or greater than all races combined for adult and pediatric asthma, all diabetic conditions, hypertension, and lower extremity amputations. Based upon this data it is estimated that 2008 ACSC charges will exceed \$1.1 billion.*

Current statistics for 31 hospitals operating in Connecticut revealed that the average age at which Blacks were hospitalized for chronic diseases such as hypertension, diabetes, and cancer was 51, compared with 65 years of age for Whites and 59 years of age for Hispanics.

*Blacks and poorer patients have higher rates of avoidable hospitalizations (i.e., hospitalization for health conditions that, in the presence of comprehensive care, rarely require hospitalization). Higher rates of avoidable admissions in blacks and lower socio-economic*

*position persons may be explained, in part, by lower receipt of routine care by these populations.*

## **Legislative Impact**

Extensive research conducted through the Connecticut General Assembly to determine the legislative impact on healthcare disparities among Connecticut's African American or Black population revealed that no bills were passed between 1998 and 2006 that specifically addressed racial and ethnic disparities. This may indicate that policy makers have not considered this issue to be a major concern. And it may also support the existence of a general perception that there is equality of healthcare services for all Connecticut residents. Legislation cannot be drafted and enacted without a reason and a purpose. Clearly the answers to questions of racial and ethnic disparities have not been understood.

There is some concern when well-intentioned, financial and/or legislative initiatives create indirect or unattended consequences. For example, a reduction in podiatric services, which involve foot care, can generate a disproportionate reduction of podiatric treatments. This, in turn, can lead to a disproportionate increase in lower extremity amputations—an unintended consequence.

Several bills have been introduced to Connecticut's 2007 General Assembly intended to close the healthcare gap. These bills, if enacted in their current form, would not fully address the root causes of racial and ethnic disparities that exist in Connecticut. What is needed is a comprehensive healthcare bill with specific purposes, goals, objectives, strategies, timelines, and funding. The climate appears to be right at this time for a concerted effort to make this the number one priority of the state's policy makers.

## **XIV. RECOMMENDATIONS**

It is clear from this study that health disparities exist in the African American communities and throughout Connecticut, and are, indeed, very prominent in the lives of community members.

The participation of the focus groups added the context, perceptions, and emotions behind the statistics and epidemiological analyses. *This Health Status Report should not be viewed as a strategic plan, but rather as a tool that indicates the need for the State of Connecticut to develop a comprehensive, time-phased, strategic plan to address healthcare disparities within Connecticut's African American population. A plan with clear goals, objectives, and timetables is necessary to address this complex problem.*

The following recommendations are proposed in order: (1) to initiate a process that will serve as a guide and a roadmap to facilitating the elimination of health disparities within the communities of color in the State of Connecticut; (2) to review the intended and unintended consequences of policies that contribute to health disparities; and (3) to encourage the continued involvement of key stakeholders for sustained health system changes.

### **The Connecticut NAACP Health Initiative**

The Connecticut State Conference of NAACP Branches, with over 10,000 members statewide will become the '**Healthcare Voice**' and assume the lead in advocating Connecticut's General Assembly to enact comprehensive health care legislation. *This advocacy would be in the form of a statewide proactive campaign to include an aggressive effort to educate the state's African American community about existing health care disparities and the role each individual can play to eliminate them.* In addition, the campaign should include other individuals,

organizations, and institutions who share the desire for enactment of comprehensive healthcare legislation. This statewide activism by the Connecticut Conference of NAACP Branches will ensure that all citizens in Connecticut receive equal, fair, and timely healthcare services.

## **RECOMMENDATIONS**

### **I. LEGISLATIVE POLICY**

#### **Review Legislative Policies and Bills**

##### **Institutive Legislative and Policy Review Initiatives**

Legislative policies and bills are not reviewed by an independent agency to determine their potential disproportionate impact on all citizens. An example of this would have been the significant impact on lower body amputations caused by limiting podiatric access to SAGA recipients at risk for diabetes complications.

All legislative policies and bills should be vetted through the proposed Office of Minority Health in order to prevent any disproportionate impact on any minority group, thereby avoiding health inequities.

#### **Legislative support.**

#### **Merge the Departments of Public Health and Social Services**

Each year the Department of Public Health reports on the health status of Connecticut citizens and the health inequities that exist within the state. It is clear that there is little coordination with the agency charged with providing access and programs (Department of Social Services) and the agency charged with monitoring and safeguarding health status (Department of Public Health).

These departments should be consolidated to improve delivery of services and reduce current and long-term healthcare costs to this State.

## II. ACCESS

### **Create an Office of Minority Health**

There is a significant lack of coordinators, accountability, and a cohesive plan for coordinating the various public and private initiatives to minority health.

An Office of Minority Health should be established to address minority health issues and healthcare inequities.

### **Establish Academic Medical Center Accountability**

The IOM report states that the lack of inclusion of minorities in teaching settings directly impacts inequities within the healthcare system. Currently, accountability for minority inclusion, within the state, does not reside within any office of our state government.

Academic medical centers and other teaching facilities must be fully engaged in developing a diverse workforce in the state, with a strong emphasis on the training of future doctors and other care providers. The issue of minority clinical staff must be included in any effort to reduce and/or eliminate inequities in health care.

## III. PUBLIC POLICY

### **Marry Healthcare Licensing and Approvals with Disparity Objectives**

Licenses and approvals are not linked to impact programs that address disparity objectives.

The State of Connecticut should use its power and influence to establish quantifiable goals that address disparity objectives in health care.

### **Develop Private and Public Programs With State Plans**

Currently, licenses are approved that are not tied to a state plan. Two examples where access is a significant state issue are childhood obesity and the emerging adult sickle cell crisis.

The State of Connecticut should incorporate accountability within new/expansion programs in order to address this inequity.

### **Change Collection of Ethnic and Racial Demographic Data**

Currently, the Department of Public Health does not collect ethnic and racial demographics beyond the broad African American and Hispanic categories. The absence of subgroup data may adversely impact demographic analyses and assessments.

Change the data collection procedures to include subgroup data.

### **Establish New Local Level Partnerships**

The absence of health partnerships at the local level reduces healthcare effectiveness.

Establish new partnerships with local governing bodies and the NAACP in order to reduce healthcare inequities. Individuals, families, and neighborhoods have to be held accountable and will be supported in closing gaps as noted in this Health Status Report.

## **IV. INSURANCE**

### **Invest in Health Prevention and Promotion**

Currently, the cost of certain health care that is avoidable and preventable in many cases is caused by health inequities. The cost of “loss of productive days” is enormous and creates an unnecessary expense for many employers.

The Connecticut Business & Industry Association (CBIA) should invest in health prevention and promotion in order to reduce costs and increase economic profitability and development in the state realize full economic potential of state workforce.

### **Establish Pay-for-Performance Requirement in MCO Contracts**

Currently MCO contracts do not include a “pay-for-performance” provision, which will impact asthma care and childhood obesity situations.

Establish a “pay-for-performance” provision in MCO contracts.



## **XV. ACKNOWLEDGMENTS**

James E. Rawlings, MPH, NAACP Health Committee Chair

Rosa Browne, MBA, NAACP Health Committee Vice-Chair

Dr. John Nwangwu, Principal Investigator Consultant

Dr. Laura Burleson, Health Researcher

Dr. Jean Breny Bontempi, Health Researcher

Elizabeth Myung Sook Krause, Connecticut Health Foundation

J P Grant Management

Charles E. Hoffler & Associates

NAACP Statewide Health Committee

- Cicero B. Booker, Jr.
- Fannie Irene Pittman
- Anna Stephenson
- Carla Giles

Blue Ribbon Health Advisory Committee  
Alliance Foundation

## **NAACP Connecticut Statewide Blue Ribbon Health Advisory Committee Members**

*Scot X. Esdaile* – President CT State Conference of NAACP Branches  
*James Rawlings, MPH* – Chair CT State Conference of NAACP Branches Health Committee  
*Rosa Browne, MBA* – Co-chair CT State Conference of NAACP Branches Health Committee

### **Committee Members**

*Elaine Anderson, MPH, Public Health Practice, Branford*  
*Harris Foster, Jr., MD, Urology, Woodbridge*  
*Roslyn Hamilton, MPH, Program Officer, New Haven*  
*Ralph Jean-Mary, MHA Hospital Administration, New Haven*  
*Ervin Jones, MD, Obstetrics and Gynecology, Monroe*  
*Tish Knobf, PhD, Nursing, Woodbridge*  
*Forrester Lee, MD, Cardiology, Hamden*  
*Lief Mitchell, MPH, HIV/AIDS Program Management, New Haven*  
*Alondra Nelson, PhD, Anthropology, New Haven*  
*Heather Reynolds, MSN, Midwifery, New Haven*  
*Gary Rhule, MD, Health Administration, Hartford*  
*Marie Roberto, PhD., Epidemiology, Cromwell*  
*Vine Samuels, MPH, Cancer Program Management, New Haven*  
*Brian Singletary, DDS, Dentistry, Marlborough*  
*Tory Westbrook, MD, General Practice, East Hampton*